

ASSEMBLY BILL

No. 2400

Introduced by Assembly Member Plescia

February 23, 2006

An act to amend Sections 139.31, 4616, 5307.1, and 5318 of, and to add Section 4610.5 to, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2400, as introduced, Plescia. Workers' compensation.

(1) Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of employment.

Existing law requires every employer to establish a utilization review process, either directly or through its insurer or entity with which an employer or insurer contracts for these services, including procedures for preauthorization of medical services.

This bill would also prohibit nonemergency outpatient surgery, as specified, from being performed unless the treating physician or the facility has received a service preauthorization from the insurer or self-insured employer.

(2) Existing law provides that it is unlawful for a physician to refer a person for medical goods or services, including outpatient surgery services, whether for treatment or medical-legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

Existing law also provides for an exemption from this prohibition for outpatient surgical centers when the referring physician obtains a

service preauthorization from the insurer or self-insured employer after disclosure of the financial relationship.

This bill would require the insurer or self-insured employer to process a service preauthorization request in accordance with provisions relating to utilization review.

(3) Existing law authorizes an insurer or employer to establish or modify a medical provider network for the provision of medical treatment to injured employees.

This bill would prohibit a medical provider network from including an ambulatory surgical center.

(4) Existing law requires the administrative director to adopt and revise periodically an official medical fee schedule for services, drugs, fees, and goods. Existing law prohibits the maximum facility fee for services performed in an ambulatory surgical center or in a hospital outpatient department from exceeding 120% of the fee paid by Medicare for the same services performed in a hospital outpatient department.

This bill would establish reimbursement methodologies for surgical implants and accessories or supplies directly used with an implant provided in connection with an ambulatory surgical center or hospital outpatient department, and would make other technical, nonsubstantive changes.

(5) Existing law requires that implantable medical devices, hardware, and instrumentation for certain Diagnostic Related Groups (DRGs) be separately reimbursed in accordance with a prescribed formula.

This bill would require that comparable procedures performed on an outpatient basis be similarly reimbursed in accordance with this formula.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 139.31 of the Labor Code is amended to
2 read:

3 139.31. The prohibition of Section 139.3 shall not apply to or
4 restrict any of the following:

5 (a) A physician may refer a patient for a good or service
6 otherwise prohibited by subdivision (a) of Section 139.3 if the

1 physician's regular practice is where there is no alternative
2 provider of the service within either 25 miles or 40 minutes
3 traveling time, via the shortest route on a paved road. A
4 physician who refers to, or seeks consultation from, an
5 organization in which the physician has a financial interest under
6 this subdivision shall disclose this interest to the patient or the
7 patient's parents or legal guardian in writing at the time of
8 referral.

9 (b) A physician who has one or more of the following
10 arrangements with another physician, a person, or an entity, is
11 not prohibited from referring a patient to the physician, person,
12 or entity because of the arrangement:

13 (1) A loan between a physician and the recipient of the
14 referral, if the loan has commercially reasonable terms, bears
15 interest at the prime rate or a higher rate that does not constitute
16 usury, is adequately secured, and the loan terms are not affected
17 by either party's referral of any person or the volume of services
18 provided by either party.

19 (2) A lease of space or equipment between a physician and the
20 recipient of the referral, if the lease is written, has commercially
21 reasonable terms, has a fixed periodic rent payment, has a term of
22 one year or more, and the lease payments are not affected by
23 either party's referral of any person or the volume of services
24 provided by either party.

25 (3) A physician's ownership of corporate investment
26 securities, including shares, bonds, or other debt instruments that
27 were purchased on terms that are available to the general public
28 through a licensed securities exchange or NASDAQ, do not base
29 profit distributions or other transfers of value on the physician's
30 referral of persons to the corporation, do not have a separate class
31 or accounting for any persons or for any physicians who may
32 refer persons to the corporation, and are in a corporation that had,
33 at the end of the corporation's most recent fiscal year, total gross
34 assets exceeding one hundred million dollars (\$100,000,000).

35 (4) A personal services arrangement between a physician or an
36 immediate family member of the physician and the recipient of
37 the referral if the arrangement meets all of the following
38 requirements:

39 (A) It is set out in writing and is signed by the parties.

1 (B) It specifies all of the services to be provided by the
2 physician or an immediate family member of the physician.

3 (C) The aggregate services contracted for do not exceed those
4 that are reasonable and necessary for the legitimate business
5 purposes of the arrangement.

6 (D) A written notice disclosing the existence of the personal
7 services arrangement and including information on where a
8 person may go to file a complaint against the licensee or the
9 immediate family member of the licensee, is provided to the
10 following persons at the time any services pursuant to the
11 arrangement are first provided:

12 (i) An injured worker who is referred by a licensee or an
13 immediate family member of the licensee.

14 (ii) The injured worker's employer, if self-insured.

15 (iii) The injured worker's employer's insurer, if insured.

16 (iv) If the injured worker is known by the licensee or the
17 recipient of the referral to be represented, the injured worker's
18 attorney.

19 (E) The term of the arrangement is for at least one year.

20 (F) The compensation to be paid over the term of the
21 arrangement is set in advance, does not exceed fair market value,
22 and is not determined in a manner that takes into account the
23 volume or value of any referrals or other business generated
24 between the parties, except that if the services provided pursuant
25 to the arrangement include medical services provided under
26 Division 4; (*commencing with Section 3200*) compensation paid
27 for the services shall be subject to the official medical fee
28 schedule promulgated pursuant to Section 5307.1 or subject to
29 any contract authorized by Section 5307.11.

30 (G) The services to be performed under the arrangement do
31 not involve the counseling or promotion of a business
32 arrangement or other activity that violates any state or federal
33 law.

34 (c) (1) A physician may refer a person to a health facility, as
35 defined in Section 1250 of the Health and Safety Code, to any
36 facility owned or leased by a health facility, or to an outpatient
37 surgical center, if the recipient of the referral does not
38 compensate the physician for the patient referral, and any
39 equipment lease arrangement between the physician and the

1 referral recipient complies with the requirements of paragraph (2)
2 of subdivision (b).

3 (2) Nothing shall preclude this subdivision from applying to a
4 physician solely because the physician has an ownership or
5 leasehold interest in an entire health facility or an entity that
6 owns or leases an entire health facility.

7 (3) A physician may refer a person to a health facility for any
8 service classified as an emergency under subdivision (a) or (b) of
9 Section 1317.1 of the Health and Safety Code. For
10 nonemergency outpatient diagnostic imaging services performed
11 with equipment for which, when new, has a commercial retail
12 price of four hundred thousand dollars (\$400,000) or more, the
13 referring physician shall obtain a service preauthorization from
14 the insurer, or self-insured employer. Any oral authorization shall
15 be memorialized in writing within five business days.

16 (d) A physician compensated or employed by a university may
17 refer a person to any facility owned or operated by the university,
18 or for a physician service, to another physician employed by the
19 university, provided that the facility or university does not
20 compensate the referring physician for the patient referral. For
21 nonemergency diagnostic imaging services performed with
22 equipment that, when new, has a commercial retail price of four
23 hundred thousand dollars (\$400,000) or more, the referring
24 physician shall obtain a service preauthorization from the insurer
25 or self-insured employer. An oral authorization shall be
26 memorialized in writing within five business days. In the case of
27 a facility which is totally or partially owned by an entity other
28 than the university, but which is staffed by university physicians,
29 those physicians may not refer patients to the facility if the
30 facility compensates the referring physician for those referrals.

31 (e) The prohibition of Section 139.3 shall not apply to any
32 service for a specific patient that is performed within, or goods
33 that are supplied by, a physician's office, or the office of a group
34 practice. Further, ~~the provisions of~~ Section 139.3 shall not alter,
35 limit, or expand a physician's ability to deliver, or to direct or
36 supervise the delivery of, in-office goods or services according to
37 the laws, rules, and regulations governing his or her scope of
38 practice. With respect to diagnostic imaging services performed
39 with equipment that, when new, had a commercial retail price of
40 four hundred thousand dollars (\$400,000) or more, or for

1 physical therapy services, or for psychometric testing that
2 exceeds the routine screening battery protocols, with a time limit
3 of two to five hours, established by the administrative director,
4 the referring physician obtains a service preauthorization from
5 the insurer or self-insured employer. Any oral authorization shall
6 be memorialized in writing within five business days.

7 (f) The prohibition of Section 139.3 shall not apply where the
8 physician is in a group practice as defined in Section 139.3 and
9 refers a person for services specified in Section 139.3 to a
10 multispecialty clinic, as defined in subdivision (l) of Section
11 1206 of the Health and Safety Code. For diagnostic imaging
12 services performed with equipment that, when new, had a
13 commercial retail price of four hundred thousand dollars
14 (\$400,000) or more, or physical therapy services, or
15 psychometric testing that exceeds the routine screening battery
16 protocols, with a time limit of two to five hours, established by
17 the administrative director, performed at the multispecialty
18 facility, the referring physician shall obtain a service
19 preauthorization from the insurer or self-insured employer. Any
20 oral authorization shall be memorialized in writing within five
21 business days.

22 (g) The requirement for preauthorization in Sections (c), (e),
23 and (f) shall not apply to a patient for whom the physician or
24 group accepts payment on a capitated risk basis.

25 (h) The prohibition of Section 139.3 shall not apply to any
26 facility when used to provide health care services to an enrollee
27 of a health care service plan licensed pursuant to the Knox-Keene
28 Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing
29 with Section 1340) of Division 2 of the Health and Safety Code).

30 (i) The prohibition of Section 139.3 shall not apply to an
31 outpatient surgical center, as defined in paragraph (7) of
32 subdivision (b) of Section 139.3, ~~where~~ *when* the referring
33 physician obtains a service preauthorization from the insurer or
34 self-insured employer after disclosure of the financial
35 relationship. *The insurer or self-insured employer shall process a*
36 *service preauthorization request in accordance with Section*
37 *4610.*

38 SEC. 2. Section 4610.5 is added to the Labor Code, to read:

39 4610.5. (a) No nonemergency outpatient surgery shall be
40 performed unless the treating physician or facility has received a

1 service preauthorization from the insurer or self-insured
2 employer. The insurer or self-insured employer shall process this
3 service preauthorization in accordance with Section 4610.

4 (b) For the purposes of this section, “outpatient surgery” has
5 the same meaning as used in paragraph (7) of subdivision (b) of
6 Section 139.3.

7 SEC. 3. Section 4616 of the Labor Code is amended to read:

8 4616. (a) (1) On or after January 1, 2005, an insurer or
9 employer may establish or modify a medical provider network
10 for the provision of medical treatment to injured employees. The
11 network shall include physicians primarily engaged in the
12 treatment of occupational injuries and physicians primarily
13 engaged in the treatment of nonoccupational injuries. The goal
14 shall be at least 25 percent of physicians primarily engaged in the
15 treatment of nonoccupational injuries. The administrative
16 director shall encourage the integration of occupational and
17 nonoccupational providers. The number of physicians in the
18 medical provider network shall be sufficient to enable treatment
19 for injuries or conditions to be provided in a timely manner. The
20 provider network shall include an adequate number and type of
21 physicians, as described in Section 3209.3, or other providers, as
22 described in Section 3209.5, to treat common injuries
23 experienced by injured employees based on the type of
24 occupation or industry in which the employee is engaged, and the
25 geographic area where the employees are employed. *The network*
26 *shall not include a licensed or unlicensed ambulatory surgical*
27 *center.*

28 (2) Medical treatment for injuries shall be readily available at
29 reasonable times to all employees. To the extent feasible, all
30 medical treatment for injuries shall be readily accessible to all
31 employees. With respect to availability and accessibility of
32 treatment, the administrative director shall consider the needs of
33 rural areas, specifically those in which health facilities are
34 located at least 30 miles apart.

35 (b) The employer or insurer shall submit a plan for the medical
36 provider network to the administrative director for approval. The
37 administrative director shall approve the plan if he or she
38 determines that the plan meets the requirements of this section. If
39 the administrative director does not act on the plan within 60
40 days of submitting the plan, it shall be deemed approved.

1 (c) Physician compensation may not be structured in order to
2 achieve the goal of reducing, delaying, or denying medical
3 treatment or restricting access to medical treatment.

4 (d) If the employer or insurer meets the requirements of this
5 section, the administrative director may not withhold approval or
6 disapprove an employer's or insurer's medical provider network
7 based solely on the selection of providers. In developing a
8 medical provider network, an employer or insurer shall have the
9 exclusive right to determine the members of their network.

10 (e) All treatment provided shall be provided in accordance
11 with the medical treatment utilization schedule established
12 pursuant to Section 5307.27 or the American College of
13 Occupational Medicine's Occupational Medicine Practice
14 Guidelines, as appropriate.

15 (f) No person other than a licensed physician who is
16 competent to evaluate the specific clinical issues involved in the
17 medical treatment services, when these services are within the
18 scope of the physician's practice, may modify, delay, or deny
19 requests for authorization of medical treatment.

20 (g) On or before November 1, 2004, the administrative
21 director, in consultation with the Department of Managed Health
22 Care, shall adopt regulations implementing this article. The
23 administrative director shall develop regulations that establish
24 procedures for purposes of making medical provider network
25 modifications.

26 SEC. 4. Section 5307.1 of the Labor Code is amended to
27 read:

28 5307.1. (a) The administrative director, after public hearings,
29 shall adopt and revise periodically an official medical fee
30 schedule that shall establish reasonable maximum fees paid for
31 medical services other than physician services, drugs and
32 pharmacy services, health care facility fees, home health care,
33 and all other treatment, care, services, and goods described in
34 Section 4600 and provided pursuant to this section. Except for
35 physician services, all fees shall be in accordance with the
36 fee-related structure and rules of the relevant Medicare and
37 Medi-Cal payment systems, provided that employer liability for
38 medical treatment, including issues of reasonableness, necessity,
39 frequency, and duration, shall be determined in accordance with
40 Section 4600. Commencing January 1, 2004, and continuing until

1 the time the administrative director has adopted an official
2 medical fee schedule in accordance with the fee-related structure
3 and rules of the relevant Medicare payment systems, except for
4 the components listed in ~~subdivisions (k) and (l)~~ *subdivision (j)*,
5 maximum reasonable fees shall be 120 percent of the estimated
6 aggregate fees prescribed in the relevant Medicare payment
7 system for the same class of services before application of the
8 inflation factors provided in ~~subdivision (e)~~ *(g)*, except that for
9 pharmacy services and drugs that are not otherwise covered by a
10 Medicare fee schedule payment for facility services, the
11 maximum reasonable fees shall be 100 percent of fees prescribed
12 in the relevant Medi-Cal payment system. Upon adoption by the
13 administrative director of an official medical fee schedule
14 pursuant to this section, the maximum reasonable fees paid shall
15 not exceed 120 percent of estimated aggregate fees prescribed in
16 the Medicare payment system for the same class of services
17 before application of the inflation factors provided in ~~subdivision~~
18 ~~(e)~~ *(g)*. Pharmacy services and drugs shall be subject to the
19 requirements of this section, whether furnished through a
20 pharmacy or dispensed directly by the practitioner pursuant to
21 subdivision (b) of Section 4024 of the Business and Professions
22 Code.

23 (b) In order to comply with the standards specified in
24 subdivision (f), the administrative director may adopt different
25 conversion factors, diagnostic related group weights, and other
26 factors affecting payment amounts from those used in the
27 Medicare payment system, provided estimated aggregate fees do
28 not exceed 120 percent of the estimated aggregate fees paid for
29 the same class of services in the relevant Medicare payment
30 system.

31 (c) *(1)* Notwithstanding subdivisions (a) and (d), the
32 maximum facility fee for services performed in an ambulatory
33 surgical center, or in a hospital outpatient department, may not
34 exceed 120 percent of the fee paid by Medicare for the same
35 services performed in a hospital outpatient department.

36 *(2)* In addition to the facility fee, surgical implants and
37 accessories or supplies that are used directly with an implant to
38 achieve the therapeutic benefit of the implant or to assure the
39 proper function of the implant shall be reimbursed to the
40 ambulatory surgical center or hospital outpatient department at

1 *the facility's documented paid cost, plus an additional 10 percent*
2 *of the facility's documented paid cost not to exceed a maximum*
3 *of two hundred fifty dollars (\$250), plus any sales tax and*
4 *shipping and handling charges actually paid.*

5 (d) If the administrative director determines that a medical
6 treatment, facility use, product, or service is not covered by a
7 Medicare payment system, the administrative director shall
8 establish maximum fees for that item, ~~provided that.~~ *However,*
9 *the maximum fee paid shall not exceed 120 percent of the fees*
10 *paid by Medicare for services that require comparable resources.*
11 If the administrative director determines that a pharmacy service
12 or drug is not covered by a Medi-Cal payment system, the
13 administrative director shall establish maximum fees for that
14 item, provided, however, that the maximum fee paid shall not
15 exceed 100 percent of the fees paid by Medi-Cal for pharmacy
16 services or drugs that require comparable resources.

17 (e) Prior to the adoption by the administrative director of a
18 medical fee schedule pursuant to this section, for any treatment,
19 facility use, product, or service not covered by a Medicare
20 payment system, including acupuncture services, or, with regard
21 to pharmacy services and drugs, for a pharmacy service or drug
22 that is not covered by a Medi-Cal payment system, the maximum
23 reasonable fee paid shall not exceed the fee specified in the
24 official medical fee schedule in effect on December 31, 2003.

25 (f) Within the limits provided by this section, the rates or fees
26 established shall be adequate to ensure a reasonable standard of
27 services and care for injured employees.

28 (g) (1) (A) Notwithstanding any other provision of law, the
29 official medical fee schedule shall be adjusted to conform to any
30 relevant changes in the Medicare and Medi-Cal payment systems
31 no later than 60 days after the effective date of those changes,
32 provided that both of the following conditions are met:

33 (i) The annual inflation adjustment for facility fees for
34 inpatient hospital services provided by acute care hospitals and
35 for hospital outpatient services shall be determined solely by the
36 estimated increase in the hospital market basket for the 12
37 months beginning October 1 of the preceding calendar year.

38 (ii) The annual update in the operating standardized amount
39 and capital standard rate for inpatient hospital services provided
40 by hospitals excluded from the Medicare prospective payment

1 system for acute care hospitals and the conversion factor for
2 hospital outpatient services shall be determined solely by the
3 estimated increase in the hospital market basket for excluded
4 hospitals for the 12 months beginning October 1 of the preceding
5 calendar year.

6 (B) The update factors contained in clauses (i) and (ii) of
7 subparagraph (A) shall be applied beginning with the first update
8 in the Medicare fee schedule payment amounts after December
9 31, 2003.

10 (2) The administrative director shall determine the effective
11 date of the changes, and shall issue an order, exempt from
12 Sections 5307.3 and 5307.4 and the rulemaking provisions of the
13 Administrative Procedure Act (Chapter 3.5 (commencing with
14 Section ~~11370~~ 11340) of Part 1 of Division 3 of Title 2 of the
15 Government Code), informing the public of the changes and their
16 effective date. All orders issued pursuant to this paragraph shall
17 be published on the Internet Web site of the ~~division~~ Division of
18 Workers' Compensation.

19 (3) For the purposes of this subdivision, the following
20 definitions apply:

21 ~~(A) "Medicare Economic Index" means the input price index~~
22 ~~used by the federal Centers for Medicare and Medicaid Services~~
23 ~~to measure changes in the costs of a providing physician and~~
24 ~~other services paid under the resource-based relative value scale.~~

25 ~~(B)~~

26 (A) "Hospital market basket" means the input price index used
27 by the federal Centers for Medicare and Medicaid Services to
28 measure changes in the costs of providing inpatient hospital
29 services provided by acute care hospitals that are included in the
30 Medicare prospective payment system.

31 ~~(C)~~

32 (B) "Hospital market basket for excluded hospitals" means the
33 input price index used by the federal Centers for Medicare and
34 Medicaid Services to measure changes in the costs of providing
35 inpatient services by hospitals that are excluded from the
36 Medicare prospective payment system.

37 (h) Nothing in this section shall prohibit an employer or
38 insurer from contracting with a medical provider for
39 reimbursement rates different from those prescribed in the
40 official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(l) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

SEC. 5. Section 5318 of the Labor Code is amended to read:

5318. (a) Implantable medical devices, hardware, and instrumentation for Diagnostic Related Groups (DRGs) 004, 496, 497, 498, 519, ~~and~~ 520, *and comparable procedures performed on an outpatient basis*, shall be separately reimbursed at the provider's documented paid cost, plus an additional 10 percent of the provider's documented paid cost, not to exceed a maximum of two hundred fifty dollars (\$250), plus any sales tax and shipping and handling charges actually paid.

(b) This section shall be operative only until the administrative director adopts a regulation specifying separate reimbursement, if

- 1 any, for implantable medical hardware or instrumentation for
- 2 complex spinal surgeries.

O